BENTON & FRANKLIN COUNTIES

COMMUNITY HEALTH IMPROVEMENT PLAN

2020

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PUBLIC HEALTH Prevent • Promote • Protect BENTON-FRANKLIN HEALTH DISTRICT

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TRI-CITIES COMMUNITY HEALTH

KADLEC

Trios Health

LOURDES HEALTH

emmaus counseling center

LETTER TO OUR COMMUNITY

To the Residents of Benton and Franklin Counties,

We are fortunate to live and work in an area with a robust group of health and service professionals dedicated to addressing the health needs of our community. As we strive to improve the overall health of our community, we need to look at all the facets of what services exist, which services are lacking, and how agencies and partners can collaborate in setting tangible goals and working together to improve health equity in the Benton and Franklin County area.

The following document outlines the Community Health Improvement Plan (CHIP), a community level plan of action informed by the months of data collection and analysis that went into the Community Health Needs Assessment. Too often, agencies and community partners are isolated in silos, unaware of the efforts and work being done across numerous sectors and industries. A truly collaborative CHIP is designed to break down those silos and bring everyone to the table. It has been developed with input from your community service providers, health care agencies, business partners, non-profit organizations, government agencies, and community members. It relies on a collective action approach, recognizing that we are stronger and more effective together. The CHIP is the culmination of those efforts, providing specific actions and commitments from local agencies and partners, to improve the health of those we serve.

COVID-19 has impacted our community in dramatic ways. As this document is being released, the long term consequences of this pandemic to our community and the agencies who operate here are still not fully known. In many ways, this crisis has not only identified, but also intensified the existing health needs of our community. Despite the delays and challenges presented by COVID-19, the health priorities in the Community Health Needs Assessment still need to be addressed. To more effectively respond to community's needs during this time of uncertainty, the CHIP has been designed to allow for greater flexibility in achieving its goals and objectives with additional efforts aimed at challenges that have been created by the COVID-19 pandemic. We hope this flexibility will allow partner agencies to continue working towards achieving these goals and objectives, while being flexible to changing funding streams and resources.

Every member of the steering committee and partner agencies engaged with this CHIP are committed to serving the community and addressing the health needs identified through the Community Health Needs Assessment process. This commitment aligns our priorities to our community with the intention of more accessible and comprehensive health care for everyone in our counties. We hope that you will join us on this endeavor and actively engage in being part of the solutions to solving these issues.

Regards,
2020 CHIP Steering Committee

OUR COMMUNITY DEMOGRAPHICS

Benton and Franklin Counties, located in South Central Washington, have a total population of approximately 290,000 people. Each of the three main municipalities that make up the Tri-Cities are located within one of these two counties; Kennewick and Richland within Benton County and Pasco within Franklin County. There are numerous other smaller cities located within this jurisdiction including Prosser, Connell, Eltopia, Benton City, West Richland, Finley, Mesa, Basin City, and Kahlotus.

The population estimates for the cities and towns within Benton and Franklin Counties in 2019:

- Benton City: 3,520
- Connell: 5,500
- Kahlotus: 165
- Kennewick: 83,670
- Mesa: 495
- Pasco: 75,290
- Prosser: 6,145
- Richland: 56,850
- West Richland: 15,340

While the population remains predominantly white, there is a substantial Hispanic/Latinx population that has more than doubled over the past two decades.

Race	Benton County	Franklin County
White	70%	39%
Hispanic (as a race)	22.5%	55.5%
Black	1.5%	1.5%
American Indian/Alaskan Native	.5%	.5%
Asian	3%	2%
Multi-race	2.5%	1.5%

Approximately 41,000 people living in the bi-county region are foreign born, regardless of citizenship status, and 30% of households report English is not the primary language spoken in the home.

The age distribution for Benton and Franklin Counties is approximately:

- 0-17 years: 28%
- 18-34 years: 22%
- 35-64 years: 37%
- 65+ years: 13%

Sources:
Washington State Office of Financial Management
Benton-Franklin Trends
Community Health Assessment Tool (CHAT)

THE IMPACT OF COVID-19

The COVID-19 pandemic has resulted in huge impacts to local communities across the nation. Washington counties, like Benton and Franklin, were hit particularly hard by the consequences of this pandemic. This disease impacted all facets of people's lives including their ability to work, their health, their ability to see a doctor, their childrens' education, their social lives, and their mental health. It quite literally affected all three health priorities highlighted in the Community Health Needs Assessment, compounding those already existing problems.

A Community Health Improvement Plan (CHIP) is supposed to outline efforts to improve identified public health issues in a community over three to five years. However, in these unprecedented times when public health issues are changing month by month, the steering committee felt it was important to allow for extra flexibility in this CHIP. Almost every goal outlined in the CHIP now has an added objective related to COVID-19 response activities. Some of those activities have not been defined at this time as they will become more apparent in the coming weeks and months. The steering committee wanted to ensure there was a place for those activities to be reflected and tracked.

COVID-19 has also caused some significant delays in starting and completing the objectives the steering committee set out to accomplish. Resources are thin, especially now, and the full impact this disease will have on our community partners and agencies is still unknown. The steering committee is deeply committed to doing what is best for all those who live in Benton and Franklin Counties and will work to address the needs that may arise as a result of this continuing, collaborative effort.

2019 COMMUNITY HEALTH NEEDS ASSESSMENT SUMMARY

PURPOSE:

The Community Health Needs Assessment (CHNA) helps determine which critical health needs the community will focus on over the next three to five years. It is a systematic and shared process for identifying and analyzing community needs and assets throughout Benton and Franklin counties from Prosser to Connell and Hover to Hanford. The 2019 CHNA was the result of dozens of stakeholder interviews and focus groups, hours upon hours of research, multiple community and partner surveys, and a community planning session to determine the final three priority health needs in Benton and Franklin Counties.

METHODS:

The framework for the 2019 CHNA was based on a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP), reflecting the model used in the prior CHNAs and also provided by Providence St. Joseph Health (PSJH). The CHNA Steering Committee began meeting in March 2019 and is made up of representatives of the Benton-Franklin Health District (BFHD), Kadlec Regional Medical Center (Kadlec), Trios Health (Trios), Lourdes Health (Lourdes), Prosser Memorial Health (PMH), and the Benton-Franklin Community Health Alliance (BFCHA). PSJH Community Health Investment staff provided invaluable technical assistance including a Spanish-speaking facilitator and qualitative data analysis. The Benton-Franklin Health District provided the bulk of the quantitative data analysis of community health status indicators from a variety of health care and community heath survey tools. The steering committee worked diligently to ensure a wide variety of sectors and populations were represented through stakeholder interviews and community listening sessions, including representation from a wide array of sectors serving the public, and intentionally seeking to elevate the voices of diverse and marginalized population groups. In all, the steering committee completed 11 community listening sessions, 16 stakeholder interviews, received responses from over 100 stakeholder surveys, and analyzed 120 community health status indicators.

Once the data was collected and organized into preliminary groupings, the steering committee scheduled a community partner compression planning session, inviting agencies and partners from their respective distribution lists. Partners who participated in listening sessions and stakeholder interviews were also invited. Over fifty representatives from public health, hospital and health systems, behavioral health, community service organizations, first responders and business and education sectors reviewed the data, identified important issues, and came to an agreement on the critical top three priority needs for change.

RESULTS:

The three priorities are **Social Determinants of Health**, **Access and Cost of All Health Care**, and **Behavioral Health Challenges**. The community plan for how to address these priority needs is explained further in this report.

Social Determinants of Health

Access and Cost of All Health Care

Behavioral Health Challenges

STRUCTURE OF IMPLEMENTATION PLAN

The Community Health Improvement Plan (CHIP) is designed with the most broad, all encompassing components at the top. The actionable items gain clarity as the scope is narrowed down. Below is a diagram of the CHIP model. For each level of the CHIP, an example is provided from this 2020 CHIP. Since funding revenues change, new programs are constantly being developed, and with the long term impacts of COVID-19 yet to be fully known, the specific activities that will be undertaken as part of this community effort may change over time. For this reason, this CHIP report will highlight efforts down to the objective level. While some pre-planned activities may also be highlighted in narrative form as part of this report, please note that specific activities are subject to change as needed to accomodate the varying factors mentioned.

Health Priorities
Defined by the Community Health Needs Assessment. Overarching health related concern in the community.

Ex: Social Determinants of Health

Goals
Broad, supporting aim for each health priority

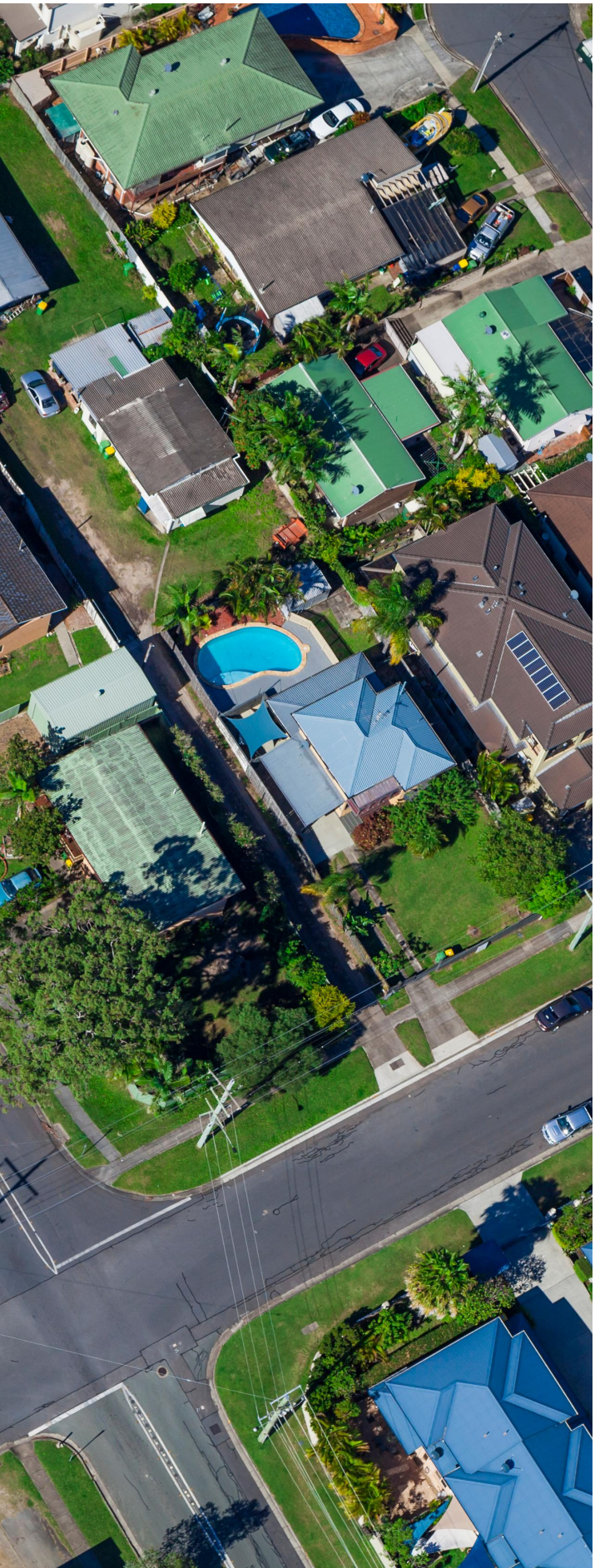
Ex: People have access to stable housing/supportive housing

Objectives
More specific, achievable community targets to support the goals

Ex: Seek to develop additional affordable housing units

Activities
Specific, assigned actions to be completed by community agencies

Ex: Increase transitional housing for veterans by eight units



PRIORITY NEED ONE: SOCIAL DETERMINANTS OF HEALTH (SDOH)

Social Determinants of Health (SDOH) are external factors that affect one's health beyond biology and genetics. Examples of SDOH include housing, education, income, health care, public safety, and food access. The community planning group referenced Maslow's hierarchy of human needs which asserts that physiological and safety needs like a home, food, water, and employment are the most basic, fundamental needs a person requires to survive. These needs are also necessary to ensure a person can achieve their greatest level of health. A lack of resources related to these needs can and does affect a person's ability to meet other health needs. A person who has no home or no food is not going to be able to effectively focus on addressing their mental health challenges or treating their chronic disease.

Initial Planned Activities

The three goals related to SDOH focus primarily on housing and food access. Some activities already planned or underway by steering committee members and partner organizations include:

- Complete a comprehensive housing and homelessness assessment
- Explore feasibility of the Built for Zero Model and, if practical, implement the program
- Increase housing units for veterans, families, and the chronically homeless
- Identify and secure funding sources dedicated to establishing a food access coalition
- Host a donated food rules summit to educate how food establishment partners should donate surplus food safely to decrease food waste and increase access to nutritious food

SDOH CHIP Goals

SDOH Goal 1: People have access to stable housing/supportive housing
Metrics to Measure: Homelessness point in time counts, school housing data**,** occupancy rates, housing availability
Objective 1.1: Increase the understanding of the actual gaps/needs related to housing/homelessness in the community
Objective 1.2: Explore and Implement Built for Zero Model
Objective 1.3: Seek to develop additional affordable housing units
Objective 1.4: Respond to community needs for housing related to the COVID-19 pandemic and response

SDOH Goal 2: People have access to nutritious foods
Metrics to Measure: Food insecurity metrics like food desert location, Healthy Youth Survey data questions about food access, WIC eligibility data points
Objective 2.1: Apply for and support grant proposals and initiatives related to food access and insecurity
Objective 2.2: Increase awareness of existing food resources
Objective 2.3: Seek funding to establish a food access coalition
Objective 2.4: Respond to community needs for safe, nutritious food related to COVID-19 pandemic and response
Objective 2.5: Increase the awareness of how to provide surplus food safely to decrease food waste and increase access to nutritious food

SDOH Goal 3: Health and SDOH are considered and evaluated in community level initiatives and agency wide policies
Metrics to Measure: Health care system data points regarding SDOH screening use, # of policies and/or partners assessed with the BFHD Health Equity and Impact Analysis Tool.
Objective 3.1: Increase Health in All Policies messages throughout larger community through active involvement and engagement with non-traditional, health impacting coalitions and groups
Objective 3.2: Increase implementation of SDOH screening in health care settings

PRIORITY NEED TWO: ACCESS AND COST OF ALL HEALTH CARE

The CHNA process identified this topic as a priority issue from the previous CHNA that needed to be continued and expanded in this iteration. In the 2013 CHNA, insurance enrollment was a focus under the access priority, but after systematic changes at the federal level that resulted in higher insured rates, the focus for the 2019 CHNA has shifted. The 2019 CHNA combines the issues of behavioral health care access and access to medical care since both components are experiencing similar issues. Provider to population ratios for Benton and Franklin Counties continue to be an issue which impacts availability and timeliness of appointments. Furthermore, the overall cost of care, even with insurance, is seen as a barrier for many in our community. Finally, this topic area did receive significant community input indicating that certain population groups have a harder time accessing behavioral and medical health care than others, including adults living with a disability, youth over 5 years of age, elderly residents, and LGBTQ+ community members.

Initial Planned Activities

The five objectives under the access priority need include a wide variety of proposed initial activities. These activities focus primarily on provider to population ratios and better access to existing resources. Some of the activities already planned or occurring by steering committee members and partner organizations include:

- Actively recruit more behavioral health providers and primary care providers to the region
- Retain more residency program graduates
- Promote and facilitate LGBTQ+ clinic training programs, as well as initiatives for other priority population groups
- Expand telehealth and virtual care options throughout the community
- Support efforts to secure funding for mobile care units
- Expand primary care services in rural areas.
- Establish additional drive through health clinics with schools and other community partners

ACCESS CHIP Goal

Access Goal 1: People have access to affordable physical and behavioral health care
Metrics to Measure: Provider to population ratios, number of additional providers not otherwise included in provider to population ratios, provider retention rates
Objective 1.1: Increase access to healthcare through expansion of nontraditional health care systems and means
Objective 1.2: Increase the provider to population ratio in Benton and Franklin Counties
Objective 1.3: Improve or expand availability and access to care providers and existing resources, particularly with priority population groups
Objective 1.4: Facilitate data collection, sharing, and compilation in order to support future and existing efforts related to access and cost of health care
Objective 1.5: Respond to community needs for access to health care services related to the COVID-19 pandemic and response

PRIORITY NEED THREE: BEHAVIORAL HEALTH CHALLENGES

Behavioral health is the term used to refer to issues once classified as "mental health." Over time, it has been expanded to encompass more areas of care including addiction, behaviors, and habits that affect overall well-being. Behavioral health challenges was identified as one of the most important unmet health-related needs in the community. Local health status indicators, as well community input from the Stakeholder Interviews and Listening Sessions, support this as a definite issue. The two goals under this health priority include upstream, prevention efforts as well as crisis intervention activities related to mental health, suicide, and substance use disorder. There is also some overlap with the access to care goal since many local behavioral health challenges stem from inadequate access to needed resources and services, or other system barriers that address behavioral health issues.

Initial Planned Activities

The steering committee identified two overarching goals related to behavioral health challenges, one that focuses more on prevention and crisis intervention efforts, and one that focuses on the system level issues that create barriers when seeking help for behavioral health concerns. Some of the initial planned activities include:

- Complete a comprehensive behavioral health needs assessment (to also include substance use disorder treatment providers)
- Support and promote community resilience messaging campaigns
- Train local providers in Mental Health First Aid
- Establish a Mental Health Navigator position to train K-12 staff and connect schools with mental health resources
- Promote and support additional means restriction events throughout the community (ex: lock box give-a-ways, medicine take back days, etc.)
- Implement the Columbia Protocol in emergency departments, hospitals, and clinics to identify risk and decrease suicides
- Support community efforts to establish a comprehensive recovery center with detox facility

Behavioral Health Challenges (BHC) CHIP Goals

BHC Goal 1: Benton and Franklin Counties are more resilient through community support and connection

Metrics to Measure: Behavioral Risk Factor Surveillance Survey and Healthy Youth Survey data points related to resilience and community connection, depression, and suicide

Objective 1.1: Increase community awareness and support prevention efforts related to behavioral health challenges

Objective 1.2: Reduce stigma around behavioral health challenges and increase community awareness amongst those who serve the community through education and outreach to agency staff members

BHC Goal 2: People receive needed behavioral health services in a timely and effective manner

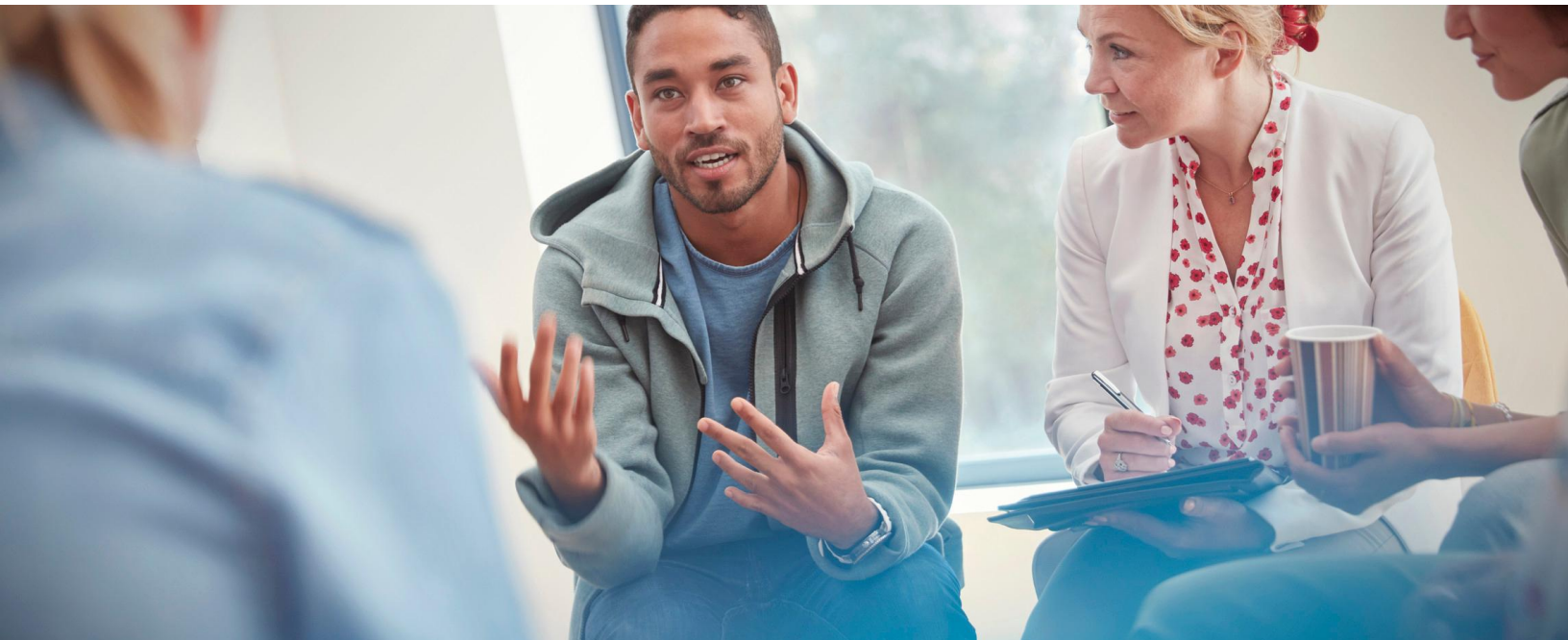
Metrics to Measure: Behavioral health system provider ratios, time to access services, number of providers

Objective 2.1: Compile and analyze community level data leveraging partnerships from different sectors to better identify and support programs addressing behavioral health challenges

Objective 2.2: Improve treatment access for substance use issues for those residing in Benton and Franklin Counties

Objective 2.3: Expand mental health services to better meet the needs of the community, based in part on the results of BHC 2.1.1

Objective 2.4: Respond to community behavioral health needs related to the COVID-19 pandemic and response



APPENDICES

Appendix 1: Acronyms and Glossary of Terms

Appendix 2: List of Community Partners

ACRONYMS AND GLOSSARY OF TERMS

BFCHA: Benton Franklin Community Health Alliance
BFHD: Benton-Franklin Health District
BRFSS: Behavioral Risk Factor Surveillance Survey
CHAT: Community Health Assessment Tool
CHIP: Community Health Improvement Plan. A Community Health Improvement Plan is a long-term, systematic effort to improve health outcomes in a community. The plan outlines actions that key partners plan to take based on the results of Community Health Needs Assessments.
CHNA: Community Health Needs Assessment. A community health needs assessment measures the health of a community at a given point in time. This can include data trends, public perceptions, capacities, and forces of change (funding, support, etc.) that may affect ability to address health issues.
GCACH: Greater Columbia Accountable Community of Health. A collaborative encompassing nine counties in SE Washington and the Yakama Nation. Its goal is to improve health, with emphasis on integrating physical and mental health in clinics, encouraging resilient communities, and working to reduce homelessness. Funded through the Health Care Authority.
HCA: Washington State Health Care Authority. Largest single purchaser of health care services in Washington. Funded by state and federal sources including Medicaid and Medicare.
HYS: Healthy Youth Survey
LGBTQ+: Demographic group title for people who identify as lesbian, gay, bi-sexual, transgender, queer, and more
MAPP: Mobilizing for Action through Planning and Partnerships
PMH: Prosser Memorial Health
PSJH: Providence St. Joseph Health
SDOH: Social Determinants of Health. The circumstances, in which people are born, grow up, live, and work and age that affect their health, functioning, risks and quality-of-life. These circumstances are in turn shaped by a wider set of forces: economics, social policies and politics (World Health Organization).
WIC: Women, Infants, and Children Program that promotes mother and child nutrition and breastfeeding

LIST OF COMMUNITY PARTNERS

3 Rivers Community Foundation
3 Rivers Village
Academy of Children's Theatre
Aging and Long-Term Care
Alzheimer's Association
American Medical Response
Amerigroup Washington
Apple Valley Dental
Avalon Health and Rehab
Ben Franklin Transit
Benton County Fire 4
Benton County Human Resources
Benton County Mental Health Court
Benton County Prosecutor
Benton County Sheriff
Benton Fire District 1
Benton Fire District 4
Benton-Franklin Community Health Alliance
Benton-Franklin Drug Court
Benton-Franklin Head Start
Benton-Franklin Health District
Benton-Franklin Medical Society
Benton-Franklin Recovery Coalition
Bethel Church
Blessed by Kess
Boys & Girls Club
Callaway Gardens
Caring Transitions
Catholic Charities
Chaplaincy Health Care
City of Kennewick
City of Pasco
City of Richland
City of West Richland
Collegium
Columbia Basin College Dental Hygiene
Columbia Basin College Nursing
Columbia Community Church
Columbia County Public Health
Communities in Schools
Communities in Schools, Benton-Franklin
Community Action Connections
Community Advisory for Mental Health
Community Alliance for Service and Advancement (C.A.S.A. LLC)
Community Health Plan of Washington
Comprehensive Healthcare
Consistent Care
Coordinated Care Health
Cork's Place
Dept. of Corrections
Domestic Violence Services of Benton-Franklin Counties
Down Syndrome Association of Mid-Columbia
Downtown Pasco Development Association
Department of Social and Health Services
Education Service District 123
Employment Security
Envision Better/ANSIL
Faith Community Nurses
Family Learning Center
Franklin County Sheriff
Franklin Fire Department 3
Futurewise
Grace Clinic
Greater Columbia ACH
Group Health Foundation
Guardian Angel Homes
Habitat for Humanity
Health Catalyst
Heartlinks Hospice and Palliative Care
Hispanic Chamber of Commerce
Historic Downtown Kennewick
Home Instead Senior Care
Hope Medical
Human Services Coalition
IA Ecology
IAPF 1433
Impact Compassion Center
Kadlec Regional Medical Center
Kaleidoscope Care Farm
Kennewick Empowering Youth Connection
Kennewick Fire Department
Kennewick Housing Authority
Kennewick Police Department
Kennewick School District
League of Education Voters
League of United Latin American Citizens

Lourdes Health Network
Lutheran Community Services
Meals on Wheels
Mindful Art
National Alliance on Mental Illness
Nuclear Care Partners
Oral Health Coalition
Oxford House
Pacific Northwest National Laboratory
Parkview Estates
Pasco Chamber of Commerce
Pasco Discovery Coalition
Pasco Fire Department
Pasco Police Department
Pasco Primary Care
Pasco Public Library
Pasco School District
People for People
Planned Parenthood
Prosser Memorial Health
Prestige Care
Professional Case Management
Prosser EMS
Prosser Fire Department
Prosser Police Department
Prosser Thrive
Providence St. Joseph Health
Recovery and Wellness
Richland Fire Department
Richland Lutheran Church
Richland Police Department
Richland Rehabilitation
Richland School District
Riverview Baptist Church
Riverview School District
Round-About Cycling
Royal Columbian Senior Living
Safe Harbor
Safe Pasco
Senior Life Resources
Somerset Counseling
Starrbright Consulting
STCU
Sue Jetter Consulting Services
Support, Advocacy & Resource Center (SARC)
Target Zero
Terra Vida
The YMCA
Three Rivers Therapy
Tri-Cities Cancer Center
Tri-Cities Community Health
Tri-Cities Food Bank
Tri-Cities Home Health
Tri-Cities Realty Group/Community Mental Health Group
Tri-Cities Washington Economic Development Council (TRIDEC)
Tri-City Regional Chamber of Commerce
Tri-City Union Gospel Mission
Trios Health
Union Gospel Mission
United Way of Benton & Franklin Counties
Walla Walla Fire District 5
Washington State University Elson Floyd Medical School
West Richland Police Department
Western Governors University
Women Helping Women Fund
Worksource Career Path Services
World Relief Tri-Cities
WSU Elson Floyd College of Medicine
WSU Extension
WSU Master Gardeners
WSU Nursing
WSU Tri-Cities
Yakima Valley Farmworkers Clinic
You Medical
Youth Suicide Prevention Coalition